MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

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MRCP Benefit Added

Effective retroactively for dates of service on or after January 1, 2005, Magnetic Resonance Cholangiopancreatography (MRCP) is a Medi-Cal benefit when billed with HCPCS Level II code S8037. MRCP procedures may, in certain situations, provide information similar to endoscopic retrograde cholangiopancreatography (ERCP), but offer some advantages.

- Iodine-based contrast is not used, avoiding allergic and osmolar risks
- Avoids ERCP with its potential attendant medical complications
- Avoids risk of sedation and/or anesthesia
- May be less costly than ERCP

Prior authorization is required for MRCP. In addition to a *Treatment Authorization Request* (TAR), providers must submit documentation of at least one of the following medical indications:

- The recipient has undergone an unsuccessful ERCP procedure and requires further evaluation.
- The recipient has altered biliary tract anatomy from prior disease or surgery that contraindicates ERCP.
- The recipient requires evaluation of a suspected congenital defect of the pancreaticobiliary tract.
- The recipient has a pancreaticobiliary medical problem suspected to present a low probability for therapeutic intervention with ERCP, but requires diagnostic work-up to direct medical management.
- The recipient has a proximal pancreaticobiliary anatomic defect that cannot be reached by ERCP, due to obstruction.
- The recipient is a young child or compromised adult where ERCP may be unsafe or cannot be performed.
- The recipient is allergic to or has a contraindication to receive iodine-based contrast media for an ERCP.

Providers may bill code S8037 with modifiers -26 (professional component), -TC (technical component) and -ZS (professional and technical component combined).

The information is reflected on manual replacement pages hcpcs ii 2 (Part 2) and radi dia 17 (Part 2).

Azacitadine is a New Benefit

Effective February 1, 2006, azacitadine 100 mg is a new Medi-Cal benefit, reimbursable with HCPCS code S0168. Azacitadine is used in treating Myelodysplatic Syndrome (MDS). HCPCS code S0168 also may be billed in conjunction with CPT-4 code 96400 (chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia).

The updated information is reflected on manual replacement pages chemo 28 (Part 2) and inject list 3 (Part 2).

Simultaneous Kidney-Pancreas Transplant Benefit

Effective retroactively to dates of service on or after July 1, 2005, inpatient providers may be reimbursed for simultaneous kidney-pancreas transplant services. To be eligible for reimbursement, providers must be authorized by the California Medical Assistance Commission (CMAC) to provide kidney-pancreas transplant services.

Providers must bill using the following national revenue and ICD-9 procedure codes:

- National revenue code 201 (intensive care, surgical) or 203 (intensive care, pediatric); and
- The primary ICD-9 procedure codes must be 52.80 (pancreatic transplant, not otherwise specified); and
- The secondary ICD-9 procedure code must be either 55.61 (renal auto-transplantation) or 55.69 (other kidney transplantation).

A *Treatment Authorization Request* (TAR) is required for reimbursement.

Physician Services
Physician services for the kidney-pancreas transplant must be billed "By Report" with HCPCS procedure code S2065 (simultaneous pancreas kidney transplantation). A TAR is required, and the operative report must accompany the claim.

Organ Procurement
Inpatient providers whose contract excludes organ procurement may bill using their outpatient number and HCPCS procedure code S2055 (harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor) for kidney-pancreas procurement. A TAR is required, and an invoice from the relevant organ procurement organization must accompany the claim.

Exception to Claims Timeliness Requirement
As an exception to the standard six-month billing timeliness requirement, a three-month grace period from January 1, 2006 through March 30, 2006 is established to allow providers to submit claims for kidney-pancreas transplant procedures with dates of service on or after July 1, 2005. Claims submitted after this three-month grace period will be subject to the standard six-month timeliness requirement. See the *Claim Submission and Timeliness Overview* section of the Part 1 manual for more information about the six-month timeliness requirement.

Providers who billed and received payment for kidney-pancreas transplants but wish to request an adjustment based on the original claim must submit a *Claims Inquiry Form* (CIF). Refer to the *CIF Overview* section of the Part 1 manual for more information.

This information is reflected on manual replacement pages transplant 5, 7 and 12 (Part 2).

Primary Surgeon Rate Increases for CPT-4 Codes 58353 and 58563

Effective for dates of service on or after February 1, 2006, the primary surgeon rates have been increased for CPT-4 codes 58353 (endometrial ablation, thermal, without hysteroscopic guidance) and 58563 (hysteroscopy, surgical; with sampling [biopsy] of endometrium and/or polypectomy, with or without D & C with endometrial ablation).

CPT-4 Code	Primary Surgeon Rate Increase From:	Primary Surgeon Rate Increase To:
58353	$ 192.04	$ 1,067.62
58563	$ 400.29	$ 1,699.98

Current rates can be viewed on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking "Medi-Cal Rates" under Provider Reference, then "View Medi-Cal Rates By Procedure Code."

Procrit, Epogen and Darbepoetin Policy Updates

Effective for dates of service on or after February 1, 2006, documentation requirements for the reimbursement of Procrit (HCPCS code X7030), Epogen (HCPCS code X6836) and Darbepoetin (HCPCS code X7493) are based on reaching specified target ranges of hematocrit and/or hemoglobin and are updated as follows:

Procrit (HCPCS code X7030)
Procrit reimbursement requires the following documentation:

- A hematocrit and/or hemoglobin level within the last three months.
- The amount of Procrit in units/kg administered to meet:
  - A hematocrit (Hct) and/or hemoglobin (Hgb) target range of 36 percent/12 g/dl with a threshold of 37.5 percent/12.5g/dl, or
  - Up to a target range of 39 percent/13g/dl with a threshold of 40.5 percent/13.5g/dl with documentation that a higher target ranger was required.

If the Hct and/or Hgb threshold is exceeded, providers must include documentation with the claim that the dosage was reduced or held in response to exceeded thresholds. Documentation requirements of target/threshold ranges for Procrit are summarized on the *Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements* form found at the end of the *Injections* section in the Part 2 manual.

Note: It is no longer a requirement that patients requiring doses higher than 150 units/kg, three times a week, have documentation of delayed or diminished response to Procrit or other treatment of anemia, including recent studies of iron stores, or that the dosage of anti-retroviral medication be at least 2,100 mg per week.

When billing Procrit for chronic kidney disease only, providers must bill using one of the following ICD-9 diagnosis codes:

- 585.1-585.5 (chronic renal failure, stages I, II, III, IV and V), or
- 585.9 (chronic kidney disease, unspecified) and 285.21 (anemia in end-stage renal disease)

In addition to current documentation requirements for all Procrit claims, providers must also include documentation that indicates a medical condition associated with anemia.

Please see **Procrit**, *page 4*

Procrit *(continued)*

Epogen (HCPCS code X6836)
Claims for Epogen must be billed in conjunction with ICD-9 diagnosis codes 285.21 and 585.6.

Darbepoetin (HCPCS code X7493)
The following ICD-9 diagnosis codes have been revised for the reimbursement of Darbepoetin:

- For anemia caused by chronic renal disease, 585.1 – 585.9
- For anemia due to treatment with chemotherapy agents for cancer, 285.29 (anemia of other chronic illness)

Note: Policy information for Darbepoetin has been moved from the *Chemotherapy* section to the *Injections* section of the Part 2 provider manual.

This updated information is reflected on manual replacement pages inject 13 thru 19 (Part 2) and the Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements form found at the end of the Injections section.

Contracted Inpatient Hospital Address Update

The California Department of Health Services (CDHS) selective hospital contracting list has been completely updated. Hospital contracts are continually changing so providers should review the information carefully.

This information is reflected on manual replacement pages contra 1 thru 15 (Part 2).

Procedure Code and Modifier(s) Combination on Claim and TAR Must Match

Effective for dates of service on or after March 1, 2006, the procedure code and modifier(s) combination on the claim submitted must match the procedure code and modifier(s) combination authorized on the *Treatment Authorization Request* (TAR). Failure to do so may result in denial of the claim.

Note: All current policies regarding the placement or order of modifiers on the claim and/or TAR remain the same.

837 v.4010A1 Electronic Claims with Attachments Now Available

Providers can now submit 837 v.4010A1 electronic claim submissions with attachments by either faxing the attachments or sending them electronically through an approved third-party vendor.

To utilize this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes an *Attachment Control Form* (ACF), which is used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment. Providers submit the electronic claim, then fax the ACF along with the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include one ACF as the first page followed by the attachment pages that correspond to that ACF. The phone number to fax attachments is 1-866-438-9377.

The electronic process involves approved third-party vendors that preprocess the attachments and send the images electronically on the provider's behalf. Medi-Cal links the faxed or electronic attachments to the appropriate electronic claim.

Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or electronic attachments. For further information regarding attachment submissions, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link and then the "Billing Instructions" link.

Patient Status Codes Update

Effective retroactively for dates of service on or after September 22, 2003, inpatient billing codes are expanded to include all national patient status codes.

New Patient Status Code 66
Effective for dates of service on or after January 1, 2006, inpatient providers may bill using patient status code 66 (discharged/transferred to a Critical Access Hospital [CAH]) when appropriate.

The following is the complete list of valid national patient status codes.

Code	Description
01	Discharge to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility with Medicare certification
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to a non-Medicare Prospective Payment System (PPS) children's hospital or non-Medicare PPS cancer hospital for inpatient care
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
09	Admitted as inpatient to this hospital
20	Expired
30	Still a patient
40	Expired at home
41	Expired in a medical facility
42	Expired – place unknown
43	Discharged/transferred to a federal health care facility
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified Long Term Care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)

Note: Providers are reminded that the day of discharge/death is not reimbursable unless it is the day of admission.

This updated information is reflected on manual replacement page cont ip 7 (Part 2).

Updated Crossover Billing Instructions for Outpatient Services

On October 24, 2005, new requirements for paper crossover claims for outpatient services were implemented to coincide with the automatic electronic crossover claims processed through United Government Services, LLC (UGS) or Mutual of Omaha. The major changes involve:

- Billing Medi-Cal with the same codes billed to Medicare
- Attaching a PC Print single claim detail version of the *Medicare National Standard Intermediary Remittance Advice* (Medicare RA) to all paper crossover claims for outpatient services
- Availability of electronic crossover billing
- New instructions for billing claims with more than 15 detail lines

Medi-Cal no longer allows the use of interim (local) codes for Medicare/Medi-Cal crossover billing. Providers should bill Medi-Cal using the same national codes displayed on the Medicare RA.

The PC Print single claim detail version of the Medicare RA is necessary for Medi-Cal claims processing, and claims received without the proper Medicare RA will be rejected. Some providers who did not previously elect to receive the electronic 835 remittance from Medicare are having difficulty complying with this requirement. In addition, if a provider's information is not updated to include the correct Medicare provider number on the Medi-Cal Provider Master File or the provider chooses to use a Medicare intermediary other than UGS or Mutual of Omaha, the claims cannot cross over automatically and the provider must comply with the new paper billing instructions or bill Medi-Cal electronically.

To update the Medi-Cal Provider Master File with the appropriate Medicare provider number, submit a *Medi-Cal Supplemental Changes* form (DHS 6209). The form and instructions are available on the Medi-Cal Web site (from the home page, click "Provider Enrollment" and then "Application Forms"). The application must have an original signature and must include a letter on Medicare letterhead showing the provider's Medicare number. To expedite the process, the application may be sent to the California Department of Health Services (CDHS) Provider Enrollment Branch via overnight mail with a cover letter stating: "New Crossover Process. Please Expedite."

Providers having difficulty obtaining the proper Medicare RAs are urged to begin billing these crossover claims to Medi-Cal electronically. Contact the Telephone Service Center (TSC) at 1-800-541-5555 or visit the "CMC Submission Instructions" page on the Medi-Cal Web site (from the home page, click "CMC" under "Provider Resources") for information about electronic crossover billing.

Medi-Cal cannot process more than 15 lines per claim form for crossover claims for outpatient services. Therefore, crossover claims for outpatient services billed for more than 15 line items for Part B services billed to Part A Intermediaries require billing on two or more separate *UB-92 Claim Forms*. This process is called "split billing."

Submit split-billed crossover claims according to the billing instructions in the *UB-92 Completion: Outpatient Services* section and under "Part B Services Billed to Part A Intermediaries" in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section of the appropriate Part 2 manual. In addition, these claims require special crossover billing procedures:

- Each split-billed claim form must include the applicable remarks in the *Remarks* area.
- The Medicare RA must be attached to each split bill claim.
- The claim detail lines entered on the claim form must be in the same order as the RA.
- Bracket and label the RA details lines that correspond with each split bill claim.

Note: The amount entered on each split-billed claim is determined by the provider, but the sum of the amounts on each split-billed claim must equal the summary data on the Medicare RA.

Please see **Crossover Billing**, *page 7*

Crossover Billing *(continued)*

For additional information about the requirements for paper crossover billing for outpatient services, including billing examples and instructions for billing more than 15 claim lines, please refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* and *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* sections in the appropriate Part 2 manual. More detailed billing examples will be published in future *Medi-Cal Updates* and posted to the Medi-Cal Web site.

Updated information can be found on manual replacement pages medi cr op 3 thru 16 (Part 2) and medi cr op ex 1, 2 and 5 thru 11 (Part 2).

New Sterilization Consent Form for Family PACT Providers Coming Soon

Begin using the PM 330 now for sterilizations scheduled on or after February 1, 2006.

Effective for dates of service on or after February 1, 2006, claims submitted by Family PACT providers for elective sterilizations (CPT-4 codes 55250, 58600, 58615, 58670, 58671, 00851 or 00921) must adhere to all Medi-Cal policies described in the *Sterilization* section of the Part 2 provider manual, including submission of Department of Health Services sterilization *Consent Form* (PM 330). Use of the PM 330 also includes the following policy updates:

- Recipients must be a minimum of 21 years of age.
- A minimum 30-day waiting period between the recipient's consent and the date of the sterilization procedure is required.

Claims for elective sterilization from Family PACT providers for dates of service prior to February 1, 2006 must continue to follow current Family PACT policy as applied to the sterilization *Consent Form* (PM 284).

The revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) will be issued in a future *Updated Information*. For more information regarding Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555.

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for the first quarter of 2006 are listed below.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

January 23, 2006
Department of Health Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

March 20, 2006
Department of Health Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

Please see **Provider Orientation**, *page 8*

Provider Orientation *(continued)*

For a map and directions to the DHS Auditorium, go to the Family PACT Web site at **www.familypact.org** and click "map" under "Orientation Sessions."

Registration
To register for an Orientation and Update session, go to the Family PACT Web site at **www.familypact.org**, click the appropriate date under "Orientation Sessions" and print out a copy of the registration form. Fill out the form and fax it to the Office of Family Planning at (916) 650-0468.

If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228). Providers must supply the following:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

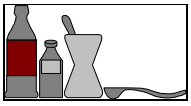
- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information regarding the Family PACT Program, please call 1-877-FAMPACT or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.



DRUG USE REVIEW
***E**ducational **I**nformation*

Use of Inhaled Long Acting Beta$_2$-Agonists in the Medi-Cal Fee-For-Service (FFS) Population

The Food and Drug Administration (FDA) has issued new warnings for all products containing long-acting beta$_2$-agonists (LABAs). The FDA has requested updates to product labels and a *Patient Medication Guide* given to patients receiving Serevent Diskus (salmeterol xinafoate), Foradil Aerolizer (formoterol fumarate) and Advair Diskus (salmeterol/fluticasone). The FDA issued the following warnings about the use of a LABA medicine for the treatment of asthma:

- Even though LABAs decrease the frequency of asthma episodes, LABAs may increase the chance of severe asthma episodes, and death when those episodes occur.
- LABAs should not be the first or only medicine used to treat asthma.
- LABAs should be added to the treatment plan after the use of low- or medium-dose corticosteroids has failed to control asthma symptoms, as recommended by the National Heart, Lung, and Blood Institute [NHLBI] *Guidelines for the Diagnosis and Treatment of Asthma*[1].
- Do not use LABA to treat sudden wheezing episodes or wheezing that is getting worse.

Please see **Beta$_2$-Agonists**, *page 9*

Beta$_2$-Agonists *(continued)*

Providers should also be aware of the following:

- The warning does not apply to chronic obstructive pulmonary disease (COPD).
- The warning does not pertain to short-acting beta agonists.

For more information about label changes or how to obtain *Patient Medication Guides*, see the following FDA Web site pages:

- **www.fda.gov/cder/drug/advisory/LABA.htm**
- **www.fda.gov/cder/drug/infopage/LABA/default.htm**

The NHLBI *Guidelines for the Diagnosis and Management of Asthma*[1] recommends the following "Stepwise Approach for Managing Asthma":

Short-acting beta$_2$-agonist * → Add inhaled corticosteroid at low to medium dose → Add long-acting beta$_2$-agonist

* All asthma patients should have a bronchodilator (inhaled short-acting beta$_2$-agonist preferred) to use as needed for symptoms.

Medi-Cal conducted a retrospective study of recipients with a recorded diagnosis of asthma to determine if prescribers/patients are adhering to recommended treatment guidelines. Patients with a diagnosis of asthma (ICD-9 code 493) on a billed medical claim, and at least one pharmacy paid claim for a short-acting beta$_2$-agonist (albuterol) between January 1, 2004 and June 30, 2004, were included in the initial analysis. The claims for these recipients were analyzed for a one-year study period between July 1, 2004 and June 30, 2005 to determine if there was appropriate asthma step-therapy with respect to the addition of inhaled corticosteroids and LABA agents. There were a total of 21,369 asthma recipients identified who received only a short-acting beta$_2$-agonist agent during the six-month lead-in period.

During the 12-month study period:

- 12 percent of asthmatics began treatment with a LABA drug before trial/failure of monotherapy with an inhaled corticosteroid.
  - Of these beneficiaries, over 99 percent moved from Albuterol directly to Advair (salmeterol/fluticasone).

For all non-Medicare Medi-Cal patients with a paid medical claim reporting a diagnosis of asthma in the same study period (N = 113,364), 26,912 recipients received at least one prescription for Advair. The study also yielded the following data:

- 15 percent of patients receiving Advair did not have a single paid claim in the same 12-month period for a short-acting beta$_2$-agonist agent as a quick reliever.
- 2 percent of patients receiving Advair had at least one occurrence of an inhaled corticosteroid filled on the same day as their Advair, with many patients showing up to 12 occurrences over the 12-month period.

Prescribers are reminded to refer to the NHLBI guidelines for the management of asthma patients. Pharmacists should carefully screen for duplication of asthma therapy and to consult patients taking LABA about the risk of severe asthma exacerbations.

Medi-Cal is monitoring the use and clinical outcomes of all long-acting beta$_2$-agonists.

To report any unexpected adverse events associated with these agents, contact the FDA MedWatch program at 1-800-FDA-1088; by FAX at 1-800-FDA-0178; by mail to MedWatch; Food and Drug Administration; HFD-410; 5600 Fishers Lane; Rockville, MD 20857-9787; or online at **www.fda.gov/medwatch/report.htm**.

[1] National Asthma Education and Prevention Program Expert Panel Report. *Guidelines for the Diagnosis and Management of Asthma–Update on Selected Topics*. Bethesda, MD: NIH/National Heart, Lung, and Blood Institute, (2002). (**www.nhlbi.nih.gov**).

Please refer to pages 36-28 and 29 in the Drug Use Review Manual.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	cardio 7/8 *
Remove:	chemo 23 thru 32
Insert:	chemo 23 thru 29
Remove and replace:	cont ip 7/8
Remove:	contra 1 thru 19
Insert:	contra 1 thru 15
Remove and replace:	hcpcs ii 1/2 inject 13 thru 34 inject list 3/4
Remove and replace from the end of the *Injections* section:	*Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements* form
Remove and replace:	medi cr op 3 thru 16 medi cr op ex 1/2
Remove:	medi cr op ex 5 thru 10
Insert:	medi cr op ex 5 thru 11 (*new*)
Remove:	radi dia 17 thru 25
Insert:	radi dia 17 thru 26 *(new)*
Remove and replace:	transplant 5 thru 8 and 11/12 ub sub 1/2 *

DRUG USE REVIEW (DUR) MANUAL

Remove from the *Education* section:	36-27
Insert:	36-27 thru 29 *(new)*

* Pages updated due to ongoing provider manual revisions.